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Eradicating IOM: A Call to Action!

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WHAT?

AOB, RME, ART are all relatively common abbreviations encountered in Paediatric Dentistry, IOM however, is a lesser known albeit potentially fatal cultural practice that is estimated to affect 25 million children at any given time¹. IOM or Infant Oral Mutilation has been described in different ways in the literature including: canine extirpation, excision, gouging and canine enucleation².

HOW?

Typically IOM is performed by local traditional practitioners, traditional birth attendants or elderly members of the community^{2,3}. Interestingly, despite improvements in accessibility to modern medicine globally, the World Health Organisation estimates that 80% of African populations continue to use traditional medicine for cultural and economic reasons as their primary source of care⁴. In IOM, the primary canine tooth buds are forcibly removed using simple instruments ranging from

bicycle spokes, knives, razor blades, metal nails and even thorns⁵. The tooth germs are commonly removed without the use of pain relief or sedation and often no disinfection occurs⁵. Evidently the procedure carries significant risks including uncontrolled bleeding, sepsis, tetanus, transmission of blood borne infections and morbidity^{1,2}. Several dental anomalies have also been reported following IOM as shown in Table 1 (adapted from Rodd and Davidson 2000)^{3,6}.

Table 1. Frequency of dental anomalies seen in cases with IOM
(From Rodd and Davidson 2000)³

Dental anomaly	Number of affected subjects (n)	Estimated population prevalence (%)
Enamel defect of primary canine	35	35.4 ^a
One or more absent primary canines	20	20.2 ^a
Retention of lower second primary incisors and distal eruption of permanent lateral incisors	12	12.1 ^a
Enamel defect of permanent canine (inconsistent with any other defects)	16	9.9 ^b
Enamel defect of lower permanent lateral incisor (inconsistent with any other defects)	9	5.6 ^b
Absent lower permanent lateral incisor	8	5.0 ^b
Non-vital lower permanent lateral incisor	2	1.2 ^b
Enamel defect of upper permanent lateral incisor (inconsistent with any other defects)	1	0.6 ^b

^a Subjects aged 3 - 9 years (n=99)

^b Subjects aged 9.1 - 17 years (n=161)

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WHERE?

The removal of the primary tooth buds is a traditional procedure that is carried out in various parts of Africa, predominantly Kenya, Ethiopia, Uganda, Somalia, Tanzania and Sudan, Figure 1.^{2,5}

Alarming cases of previously performed IOM have been reported among East African immigrants in Australia, New Zealand, the United States and England.^{3,7-9} This suggests that children may have been taken back to their country of origin to have the practice performed or it is plausible that the practice is being carried out clandestinely in their countries of resettlement.

WHY?

There is a strong cultural belief that the swelling in the area of the gums during eruption of the primary teeth (particularly canines) is a cause of persistent fever and diarrhoea. Parents commonly notice the developing tooth buds when infants are being weaned from breast-feeding, a period during which infants are most likely to have their first bouts of gastroenteritis which further reinforces these beliefs¹⁰. Such observations have long been held across various cultures and indeed Hippocrates in 400BC wrote that “teething children suffered from itching of the gums, fever, convulsions, diarrhea especially when they cut their eye teeth and when they are very corpulent and costive.”

“New beginnings; healthy teeth and healthy lives”

“New beginnings; healthy teeth and healthy lives” is an integrated multidisciplinary preventive oral health education program operating through the Refugee Health Service (RHS) at Perth Children’s Hospital. The program provides multidisciplinary assessment for newly arriving refugee children. Over the last five years of this program, several children were identified with a history of IOM that would have otherwise gone undetected. Often when asked about any previous dental history, parents will report that no extractions or dental treatment have been conducted. However, when probed deeper such as whether the child was taken to a local healer during infancy, parents will reveal a history of IOM which they may not consciously link to a typical ‘dental intervention’.

Figure 1. Countries where Infant Oral Mutilation is practiced



Figure 2 illustrates three cases of where a history of IOM was elucidated and the families were subsequently counselled regarding the dangers of the practice and consequences both dentally and psychosocially.

Call to Action

At a meeting of the Paediatric Dentistry Association of East Africa, in July 2017, a declaration was made to eliminate the practice of IOM in the region over the next decade¹. The delegates at the meeting agreed to make a call to action to stop IOM, and proposed amongst other things, a formation of a multi-agency collaboration that would help achieve the goal within the next ten years.

The increase of international migration across the globe has seen a rise in the dissemination of cultural practices to developed countries, some of these practices such as IOM and female genital mutilation can have significant biological and psychological consequences. Once a child is older,

IOM can easily go undetected and without increased awareness the practice will more than likely continue to persist. Paediatric dentists globally play an important role in identifying cases of IOM and subsequently facilitating appropriate counselling and referral in order to eradicate the practice within the next decade.

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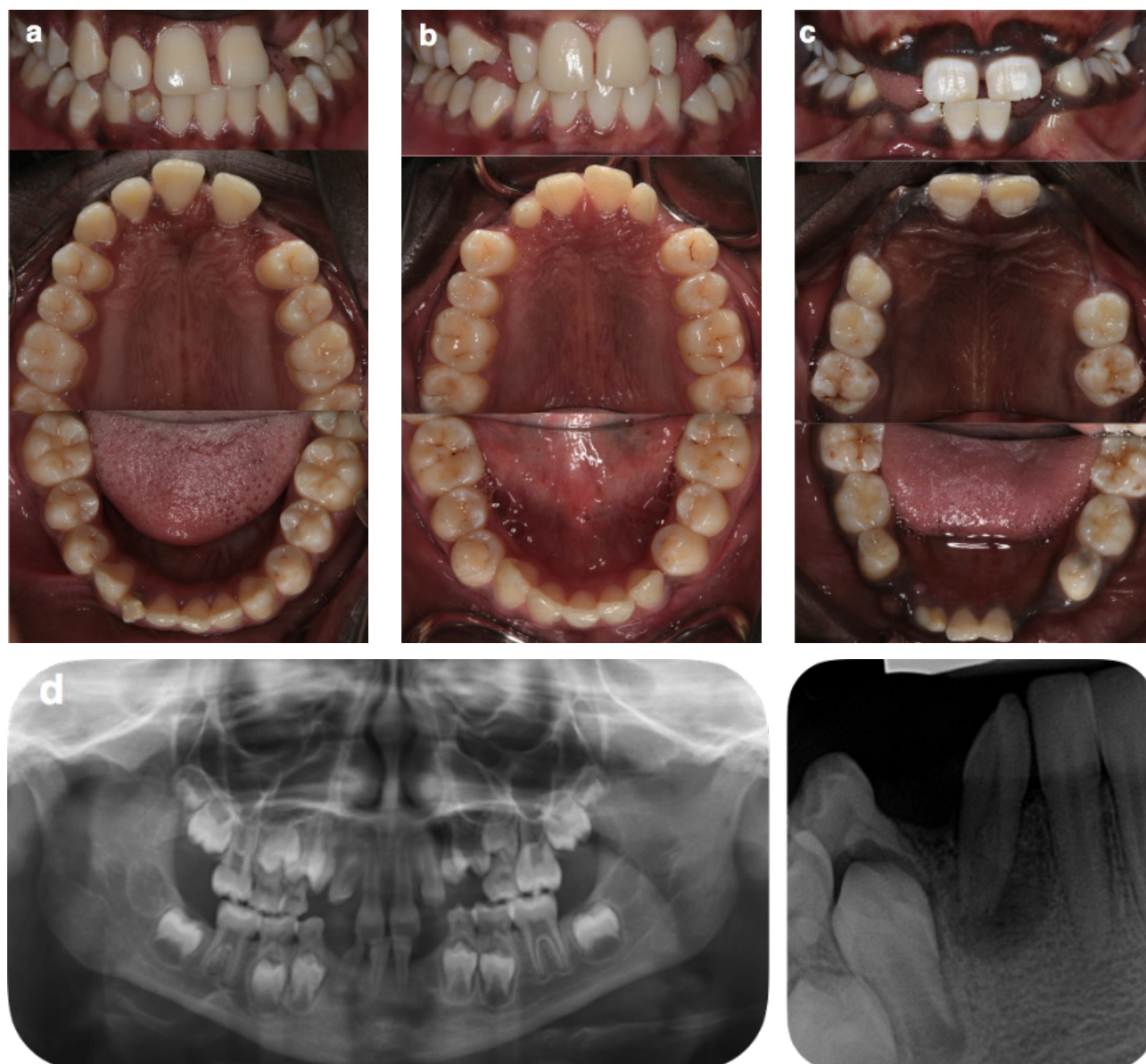


Figure 2. a) A 13-year-old girl presenting with missing teeth 22, 23 and malformed tooth 42 with subsequent malocclusion. b) a 16-year-old boy presenting with missing teeth 13, 23, 33 and incidentally microdont teeth 12 and 22. c) A 9-year-old girl presenting with multiple missing anterior teeth and malformed tooth 42 with dento-alveolar abscess. d) Radiographic investigation of Case C, revealing missing permanent teeth 32, 33, 43 and a conical structure of tooth 42 with an immature apex and associated radiolucency.

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Federal President's Report



The past year has been quite a busy one and I would like to thank all my colleagues within the Federal Executive as well as the Federal Councillors for their continuous efforts in progressing the objectives of the Society.

I am pleased to advise that through negotiations with Colgate, it has been agreed for Colgate to continue its support of our Society as our main sponsor for a further five year term commencing on the 1st of July 2020. Increased funding has been offered by Colgate. I wish to thank Colgate as the principal sponsor for our Society. We have had a long and fruitful relationship with Colgate and certainly look forward to continuing that relationship into the future.

The Synopses publication has been a long standing part of our Society's communication with members. Colgate has provided wonderful support over the past two decades with its assistance of the Synopses Publication. In July 2019 Colgate advised that it is unable to continue its support of the Synopses publication. ANZSPD's Federal Councillors and the Federal Executive Members last year decided that Synopses will undergo a transition into a digital format and be distributed electronically, reducing the environmental impact of printed publications, as well as allowing a more rapid dissemination of information to all members. It is wonderful to see this having been achieved and Dr Steven Kazoullis has done a remarkable job, as editor of the Synopses publication in recent years. Well done Steve, and I thank you for your efforts on behalf of the Society.

During my presidential term, great progress has been made with regards to the Federal constitution, it's revision and review. This document will likely provide many years of solid guidance for our Society. The federal constitution was recently submitted to an independent group of solicitors engaged by ANZSPD. The solicitors have concurred that the constitution, as it stands, complies with legislative requirements in the jurisdiction, under which ANZSPD inc. is registered.

From a historical perspective, and as many of our members would know, ANZSPD was established in 1988, after the amalgamation of two other societies, namely the Australian Society of Dentistry for Children and the New Zealand Society of Dentistry for Children. Each of the societies have had a long and distinguished track record in their own right and a distinguished group of Federal Presidents that have served these societies.

Recently at ANZSPD 20th Biennial meeting, which was held in Hobart 6-7 March, the distinguished service of past Federal Presidents was formally recognised. Crystal Plaques acknowledging their distinguished service and past Federal President's pins were presented to all past Federal Presidents in attendance at the opening ceremony. Professor Roger Hall OAM, in addition to receiving a crystal plaque and past Federal President's pin was also awarded one of the few remaining ANZSPD medals for his distinguished service to the societies and paediatric dentistry. On behalf of the society, I take this opportunity to acknowledge the distinguished services of past the past Federal Presidents of all three societies who laid the path to where the ANZSPD is today.

The Hobart Biennial was well received by those in attendance and I would like to acknowledge the efforts of Drs Debra Elsby and Giselle D'Mello and the local organising committee in organising the 2020 ANZSPD Biennial in Hobart. On behalf of the Society, I thank them for their efforts.

Progress in our field is achieved through research, education and continuing professional development. One of ANZSPD's aims within the Society is to continuously advocate for the furthering of education within the field of paediatric dentistry. Beyond great regional meetings, such as the RK Hall events as well as ANZSPD's biennial events, we are progressing well with plans for the bid for the IAPD Congress in 2025, led by the Chairman of the bid committee, Dr John Sheahan. I would like to take this opportunity to thank John for his continued efforts in that regard.

International events of such a calibre bring more great minds within the field of Paediatric Dentistry from far and wide and give colleagues the opportunity to attend a world class congress specific to the field, in our region. Such an international event would provide the opportunity to combine a remarkable line-up of leading international experts, who collectively are very much at the forefront of the field. If ANZSPD's bid is successful, there will be avenues down the track, where members can get involved in the organisation of this major event and I would like to encourage any interested member in due course to get in touch with your Federal Councillor.

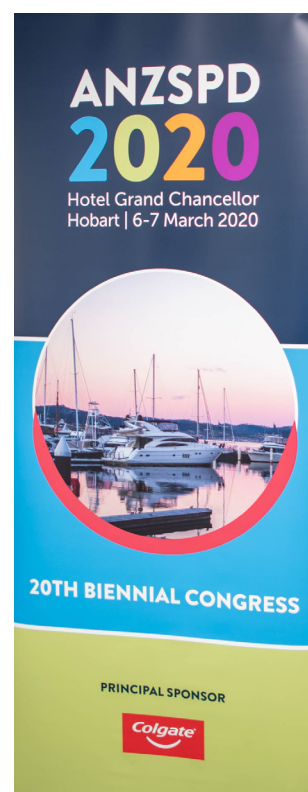
Specific thanks should be given to Dr Carmel Lloyd, the Federal Secretary for the Society, who has worked tirelessly throughout the past year and has contributed substantial amounts of her time to our Society.

Finally, my presidential term, which, as per the Federal Constitution concluded at the end of ANZSPD's Hobart Biennial, has been a tremendously busy but also enjoyable one, building on the strong foundations that were laid through the leadership of the past Presidents of our Society before me. I would like to take this opportunity to thank all Federal Councillors and members of the Federal Executive for their support during my presidential term and wish the incoming Executive team and Federal Councillors the best of success in progressing the interests of the Society.

Dr Sue S. Taji

ANZSPD Federal President

DClinDent (Qld) BDS (Adel) FPFA FIADT FICD FADI





ANZSPD's 20th Biennial Congress
Hobart, Tasmania 6-7 March 2020



Critical Appraisal of "In Vivo Validity of Proximal Caries Detection in Primary Teeth, with Histological Validation"

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Article: Subka S, Rodd H, Nugent Z, Deery C. In vivo validity of proximal caries detection in primary teeth, with histological validation. *Int J Paediatr Dent* 2019;29(4):429-438.

The original article titled "*In vivo* validity of proximal caries detection in primary teeth, with histological validation" was accepted for publication in the *International Journal of Paediatric Dentistry* in February 2019.

It was an *in vivo* study aiming to assess the validity and reproducibility of four methods of proximal caries detection in primary molar teeth. Diagnosing proximal caries is a clinical challenge due to limited accessibility and visibility of primary molar contact points. The authors referenced use of bitewing radiographs to detect proximal caries in 17 to 30-year-olds, reflecting the need for more studies in primary teeth.

The caries detection methods that the authors tested in this study were visual examination, bitewing radiographs, temporary tooth separation and a laser fluorescence pen, Diagnodent pen.

This document is a critical appraisal of the original article that aim to address the strengths and weaknesses of the methodologies used to construct this study.

Methology

The authors justified an *in vivo* study design with histological validation as there is merit in recreating clinical examination conditions, including the presence of the tongue, gingiva, saliva, and patient cooperation. Ethics approval and participant consent were obtained. A sample size calculation was performed based on the laser fluorescence device's diagnostic sensitivity in previous studies. This calculation required at least 262 surfaces available. One thousand thirty non-cavitated surfaces from 82 children were examined, making this group bigger than those of previously conducted studies.

The exclusion of all teeth with cavitated proximal lesions and patients without indicated bitewing radiographs was justified clearly. However, existing restorations, non-carious tooth surface loss and caries affecting occlusal and smooth surfaces were excluded if they were significant. There was no standardised visual examination guide used to quantify the exclusion threshold. The radiographs and diagnostic tests were all performed by a single radiographer and calibrated dentist, respectively. At the first visit, visual examination using ICDAS and laser fluorescence pen examinations were conducted. Some laser fluorescence pens have reduced sensitivity; it would have been useful to report whether the visual or laser fluorescence pen examination was performed first by the one examiner. With the laser fluorescence pen, proximal surfaces were assessed by inserting the probe tip underneath the contact area from the buccal and lingual/palatal aspects. The highest peak value of the two measurements was recorded and calibrated.

Orthodontic separators were then placed between the primary molars. Fourteen days later, the separators were removed, and the two examination methods were repeated. Patients who lost or removed the separators in the fourteen days between examinations were excluded.

Bitewing radiographs were scored on a separate occasion by the same examiner but blinded. They were interpreted using the Ekstrand criteria but split the code for caries involving the inner half of enamel and outer third of dentine into two codes.¹ The dentino-enamel junction was the dividing landmark. Anecdotaly, spread into dentine is the

threshold at which dental restoration is required. However, authors do discuss that presence of cavitation is a more appropriate threshold between operative and non-operative intervention and confirming cavitation is an essential goal of proximal caries detection methods.²

Inter-examiner reliability for clinical, radiographic and histologic methods with a second examiner was performed and reported.

The study participants then had teeth removed under general anaesthesia removed no more than three weeks later. The teeth extracted usually had advanced caries in one proximal surface but no or less advanced caries on the other. Primary molars were also extracted for balancing reasons, which was convenient for this study but may not have been possible to justify in other centres.

The extracted teeth were sectioned mesiodistally five to eight times, with each section approximately 500 µm thick. No teeth were lost during sectioning. The teeth were scored histologically using a microscope, then digital photographs were taken, and the images rescored on a computer screen. The sensitivity, specificity, positive predictive value, negative predictive value, likelihood ratios positive and negative, and the area under the receiver operating characteristics curves for each diagnostic method were calculated.

Results

Visual examination without separators, laser fluorescence pen examination and radiographic examination showed 63%, 58% and 58% of surfaces to be sound respectively (approximately equal).

When carious lesion demineralisation was in the outer half of enamel, visual examination after temporary tooth restoration presented the highest sensitivity, positive predictive value, diagnostic accuracy, and likelihood ratio positive. Radiographic examination showed the lowest sensitivity for this lesion extent.

For the detection of dentine caries, radiographic examination showed the highest sensitivity and specificity, whereas visual examination demonstrated the lowest sensitivity.

Radiographic examination and temporary tooth separation significantly improved the validity of visual examination without separation for carious lesions in the outer half of enamel and dentine. However, for carious lesions in the outer half of enamel, radiographs had the same validity as a visual examination with temporary tooth separation. They were only of superior validity for diagnosing dentine caries. The laser fluorescence pen had better validity than visual examination without separation for carious lesions in the outer half of enamel.

The authors should have specified whether their threshold for restoration was at the score ascribed to a histological lesion correlating to an ICDAS 3 (micro cavitation of enamel surface) or ICDAS 4 (intact surface with underlying shadow) carious lesion.

Unfortunately, the authors did not separate their analyses of first and second primary molars, nor whether they were in the maxilla or mandible. The individual morphology and positioning of these teeth may create variability in caries extension and detection, and with a large sample size such as this study, more detailed analysis could have been attempted.

The Results section of the abstract was a summary of the sensitivity of each diagnostic tool. However, it was beneficial to read the different methods of analyses conducted to understand the comparisons between the different tools better.

Discussion

This section of the paper did not include any description of the shape of

the primary molar contact points, nor did it mention excluding children with spacing in one or more contact points in the posterior primary dentition.

The radiographic examination had the lowest sensitivity for carious lesions in the outer half of enamel, which agreed with the findings of previous studies.³⁻⁵ In this study, radiographic examination only detected 31% of carious lesions in the outer half of enamel.

For the detection of dentine caries, radiographic examination in this study had the highest sensitivity. This finding was in agreement with findings from Novaes et al., 2009.³ Two recent *in vitro* studies have found visual examination to be better than radiographic examination for detection of proximal caries. However, the authors qualified that *in vivo* findings are closer to simulating clinical examinations.^{6,7}

Regarding the laser fluorescence pen, insertion of the head between the teeth was uncomfortable due to the tight and extensive contacts of primary molars. In this study, the specificity of the laser fluorescence pen was higher than the sensitivity, which was consistent with previous studies in primary teeth.

The patient group included and their impending extractions in three weeks from the examination, including balancing extractions, meant that the authors did not need to wait for physiological exfoliation of the primary molars and subsequently to lose control over the period between examination and exfoliation.

One limitation that the authors acknowledged is that caries extension rather than activity was considered. However, clinical and histological signs of caries activity may be hard to grade with validated criteria like the modified Ekstrand criteria used for caries extension in this study.

Key messages from this paper

This study is one of the very few studies to look at the validity of diagnostic methods for the detection of proximal caries in primary teeth *in vivo*, with histological validation and with a sample size calculation.

Clinical visual examination alone appears insufficient in detecting all

proximal carious lesions in primary teeth. Although temporary tooth separation has the highest sensitivity for carious lesions in the outer half of enamel, it is not always practical to coordinate a timely examination. This study supports the use of bitewing radiographs to detect proximal carious lesions affecting dentine, which is in contrast with conclusions from *in vitro* analyses.

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Beyond Boundaries: Dental Care for Refugee Children

Personal Perspectives

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There are more refugees and displaced people around the world than at any time since World War II – 70.8 million 25.9 million refugees, over half of whom are under the age of 18 according to the UNHCR and 37,000 people per day are forced to flee their homes because of conflict, persecution and natural disasters (Clark-Kazak 2009). Immigrant and refugee populations have been identified as priority populations in the National Oral Health Plan and present with significant disparities in oral health (Davidson et al 2006). Several barriers to care have been previously reported including cost of treatment, anxiety, cultural isolation, lack of communication and language skills, transport and alternative beliefs about dental health care (Marino et al 2001).

When families go through the migration process, dental care is usually of low priority (Selikowitz 1994). Previous research has shown that dental caries was one of the most commonly made diagnoses in the refugee health clinic (Mutch et al. 2012) and there was a gap in providing the children with access dental care (Nicol et al. 2015). Primary health care providers play a central role in initial assessment of newly arriving families, this includes an assessment of the child's oral health and facilitating appropriate linkage to community services, ensuring parents are aware of the importance of oral health care and promotion and of how to access care for their child. More often than not, these assessments and triage processes occur in primary health care settings where dentists may not be regularly involved. To this end "New beginnings; healthy teeth and healthy lives", a multidisciplinary, integrated primary oral health promotion program, was developed at the Perth Children's Hospital.

Prior to undertaking specialist training, I was acutely aware of the silos that dentistry often operates within and

Figure 1. "New beginnings; healthy teeth and healthy lives"



this undoubtedly limited the ability to engage in oral health promotion at a community level particularly in the context of vulnerable cohorts who struggle to access mainstream services. However, during my training I realised the potential for dentists, particularly paediatric dentists, to integrate with primary health care services. I began my journey with the "New beginnings; healthy teeth and healthy lives" program during my first year of training in Paediatric Dentistry (Figure 1).

The program was developed by Dr Sarah Cherian (Clinical lead, Refugee Health Service) and Dr Jilen Patel (Specialist Paediatric Dentist) to address the unmet dental needs for refugee children in 2015. Indeed, an audit of the first 1000 children presenting to the RHS found that dental caries was among the most common diagnoses for newly arriving children. Many of these children would subsequently present to hospital emergency departments with acute odontogenic infections and require the extraction of multiple teeth under general anaesthesia (Nicol et al.

2015, Davidson 2006).

As paediatric dental registrars we were introduced to the multidisciplinary refugee health clinic team (Figure 2), which consists of social workers, nurses, dietitians, immunisation nurses, psychologists, paediatricians and community liaison officers. The service also includes involvement of language services, transport and volunteers making our days full of dedicated and hard-working people.

We were involved in engaging with primary health providers to provide grass roots oral health promotion, education and triage and facilitating community linkage such that these families were better able to access care. Almost all of the consults involve the help of on-site interpreters which allows for further understanding between the clinicians and families and informed decision making. Every session spent in refugee clinic has been eye-opening and we have had the chance to be exposed to rare medical conditions and humbling stories of resilience.

Figure 2. Multidisciplinary refugee health clinic team

I have always believed that each individual can make an impact, no matter how small, and being part of a like-minded team, this impact can be magnified several times over. We all have our personal problems but when juxtaposed with the plight of refugee families, these ‘first world’ problems become incomparable. I am convinced if you are really bothered by the world around you, you can always take action. The days at refugee clinic inspired me to take part in the “Act for peace: ration challenge” with the kind support and sponsor of my friends and colleagues. This innovative project challenges you to live on the same rations afforded to a refugee family living in a detention camp (Figure 3). The experience to empathise with the struggles that refugee families face on a regular basis not only fostered a sense of deeper connectedness but also made me truly appreciate how difficult their lives are and how we so readily take for granted accessibility to basic necessities such as dental care.

Paediatric dentistry is a unique speciality in that we are provided with the opportunity to improve the quality of life of vulnerable children and their families on a daily basis. My experiences working within the “New beginnings;

healthy teeth and healthy lives” program have been nothing short of inspiring. The challenges faced by these vulnerable families alongside the ability for us to work collaboratively to support and empower them is echoed by the words of a mother of a four-year-old boy whose family fled South Sudan:

“I would feel very sad when my son was in pain because he would not be able to speak to tell me how he is feeling, he would refuse to eat and consume his food and this makes me unable to eat, when the tooth flares up and it swells he keeps touching it from outside he feels like something is not right with his face like he is disfigured and I could not sleep because he is not falling asleep because of the pain

“What you have done today has enlightened me as to how big the tooth

Figure 3. A week of ration pack for “Act For Peace” ration challenge

decay problem is, I only noticed one hole that my child pointed out to me, but today you have shown me the other teeth with cavities, I was not aware that he had this many problems, all I knew was that he had a toothache from a back tooth.

"If you could please let the people who organise this program know how grateful I am for this service, it is such a necessary service but for someone like me who is a new arrival it would be otherwise impossible for me to find a dentist..."

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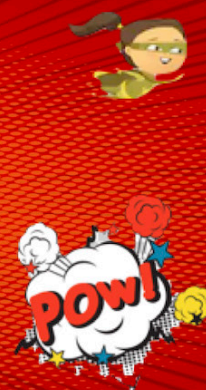
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2020 Professor Louise Brearley Messer Post-Graduate and Under-Graduate Essay Competitions

The Australian & New Zealand Society of Paediatric Dentistry (Inc)
is once again holding its Annual Essay Competitions.

Post-graduate competition

The post-graduate competition is open to all Paediatric Dentistry post-graduate students who are currently enrolled in a Doctorate, Masters or a Post Graduate Clinical Diploma in a Paediatric Dentistry program at an Australian or New Zealand Dental School.

The topic for 2020 is:

Discuss the indications for using cone beam CT radiography to all aspects of paediatric oral assessment and management compared to traditional radiographic investigations. Where CBCT is indicated, what are the barriers or precautions to be considered in obtaining these images as the first line investigation?

A first prize of AU\$2,500.00 will be awarded to the best entry.

Under-graduate competition

The under-graduate competition is open to all dental under-graduates or students enrolled in a graduate program leading to the student's first dental degree and who are enrolled in an Australian or New Zealand Dental School.

The topic for 2020 is:

Does Water Fluoridation still have a place in today's world? Explore the arguments for and against and summarise your findings to form an opinion.

A first prize of AU\$1,500.00 will be awarded to the best entry.

The Essay should not exceed 3000 words. Bibliographic style should follow that of the Australian Dental Journal. Essays are to be the work of individuals only.

The deadline for the submission of Essays is Friday 9 October 2020

Entries should be submitted to the course co-ordinator who will select the "Best Entry" and email it to the Federal Secretary ANZSPD(Inc.), Dr C Lloyd at: federal.secretary@anzspd.org.au

The winner will be announced by Monday 21 December, 2020

RECEIPT OF YOUR ENTRY WILL BE ACKNOWLEDGED BY RETURN EMAIL.

If a receipt email is not received, please send a further email to fed.secretary@anzspd and /or carmell@westnet.com.au

See <https://www.anzspd.org.au/viewStory/competitions-awards> for conditions and notes on the award.



The ANZSPD Alistair Devlin Memorial Grant

Applications are now open for the 2020 Grant!
FULL members of ANZSPD are now invited
to submit applications for the ANZSPD
Alistair Devlin Memorial Grant.

At the ANZSPD Federal Council meeting in Melbourne in February 2014, it was decided that the existing ANZSPD Grant be renamed The ANZSPD Alistair Devlin Memorial Grant in honour of Alistair's memory and to acknowledge his most significant contribution to the society.

One grant per year will be provided to the value of AUD \$2000 with eligibility restricted to current Full Members of ANZSPD (Inc.)

The grant is available for:

- An oral health initiative in Australia or New Zealand which may be an educational resource or a broad community initiative
 - A community research project directly related to child oral health
 - Support for an oral health project in Asia, Oceania or the Pacific which might be for materials, instruments, books for a school, etc.
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Applications are open for the ANZSPD Alistair Devlin Memorial Grant on 1st June 2020 and close on the 30th June 2020.

Applications will need to contact the Federal Secretary ANZSPD (Inc.) (fed.secretary@anzspd.org.au) for full application guidelines.

Federal Council will then adjudicate.

The successful applicant will be required to provide a report to the Federal Council, suitable for publication in the Society's newsletter, Synopses, by September 2021.

The Federal Council may choose not to award a grant in the event of there being no suitable applications. For more information see the Competitions and Awards page on our website.

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www.anzspd.org.au

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Mailing List

Distribution of Synopses is now digital. The mailing list for the distribution of Synopses is maintained by the Federal Secretary. It is compiled from information supplied by the Branch Secretaries. If there are errors in your email details, please contact Dr Carmel Lloyd or your Branch Secretary.

Submissions

All text for inclusion in Synopses must be submitted to the editor by email.
Address email to steven@kazoullis.com
Please include your contact details with all submissions.

UP COMING EVENTS

21-24 May 2020

American Academy of Pediatric
Dentistry Annual Session
CANCELLED
Nashville, Tennessee, USA
www.iadt-dentaltrauma.org

1-4 July 2020

EAPD 15th Congress
Hamburg, Germany
www.eapd2020.eu

12-13 December 2020

PDAA 12th Biennial Congress
RESCHEDULED FROM JUNE 2020
Seoul, Korea
www.pdaa2020.org

2-5 June 2021

IADT 21st World Congress on
Dental Traumatology
RESCHEDULED FROM 2020
www.wcdr2021.com

14-16 August 2020

AAPD Scientific Meeting
POSTPONED
Queenstown, New Zealand

27-30 May 2021

American Academy of Paediatric
Dentistry Annual Session
Boston, Massachusetts

7-12 June 2021

28th IAPD Maastricht Congress
Maastricht, The Netherlands
www.iapd2021.org

25-26 March 2022

ANZSPD Biennial Congress
Perth, Western Australia
www.anzspd2022.com